LOYAL AMERICAN LIFE INSURANCE COMPANY(R)

Claim Processing Office

P.O. Box 559004, Austin, Texas 78755-9004

EARLY DETECTION BENEFIT CLAIM FORM

(For Cancer Screening Tests)

Policy Number	Name of Patient	☐ Male ☐ Female	Date of Birth

Name and Address of Primary Insured	☐ Male ☐ Female	Date of Birth
	Social Security No.	Telephone

Spouse's Name _____

Patient is:

- ☐ Primary Insured
- ☐ Spouse
- ☐ Natural Child
- ☐ Step-Child
- ☐ Adopted Child
- ☐ *Other Child

- ☐ Married
- ☐ Unmarried
- ☐ Divorced
- ☐ Legally Separated

- ☐ Employed
- ☐ Unemployed
- ☐ Student

(Where?) _____

*(If "Other" please explain):

Home Address of Patient

Address _____ City or Town _____ State(or Province) _____ Zip Code _____

We certify that the foregoing statement and answers are true and complete to the best of our knowledge and belief.

Date _____ Signature of Insured _____ Signature of Patient (Parent if minor) _____

INSTRUCTIONS

ATTACH A COPY OF THE DOCTOR'S BILL SHOWING THE SERVICE PERFORMED, DATE OF SERVICE AND AMOUNT CHARGED. FOR ASSISTANCE, CALL TOLL FREE 1-800-633-6752.

Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false, incomplete, or deceptive statement is guilty of insurance fraud, which is a crime, and may be subject to fines and confinement in prison.

This statement does not apply in the State of Virginia

AUTOHORIZATION FORM FOR DISCLOSURES OF A CLAIMANT'S PROTECTED HEALTH INFORMATION

I hereby authorize the disclosure of protected health information about me as described below.

1. The Company, as used in this authoriztion, shall mean:
   - ☐ Great American Life Insurance Company's (R) Long Term Care Division
   - ☐ Loyal American Life Insurance Company (R)
   - ☐ United Teacher Associates Insurance Company

2. I authorize all health care providers who have provided treatment or other health care services to me to disclose all information regarding my treatment to the Company's claims and underwriting representatives by and through the Company's contracted agent, Web ISG.

3. The information which is described above will be disclosed to the Company to determine my entitlement to benefits under my health benefits plan or policy.

4. I understand that I may revoke this authorization in writing at any time, except to the extent that action has been taken by the Company in reliance on this authorization, by sending a written revocation to the Company's Claims Department at P.O. Box 26580, Austin, Texas 78755-0580.

5. This authorization will expire twenty-four (24) months from the date the authorization is signed.

6. I understand that the information which will be provided under this authorization is necessary for the Company to evaluate my entitilement to benefits under my health benefits plan or policy and that the Company will condition the provision of payment benefits to me on my providing this authorization, and my claim may be denied if I refuse to provide this authorization.

7. I understand that if the person or entity that receives my protected health information is not a health care provider or health plan covered by the federal privacy regulations, the information may be redisclosed by such person or entity and will likely no longer be protected by the federal privacy regulations. In the case of this authorization, however, the information described above will be received by a health plan which is covered by the federal privacy regulations.

8. I understand that a photocopy, facsimile copy, or electronic copy of this authorization shall be considered as effective and valid as the original.

9. I understand that I or my personal representative am entitled to receive a copy of this authorization upon request.

If you are the representative of the claimant, decribe the scope of your authority to act on the claimant's behalf:

Claimant Name

Name of claimant's personal representative, if applicable

Relationship of personal representative to the claimant

Signature of claimant (or claimant's representative)

Date of claimant's (or claimant's representative) signature

A signed copy of this form will be provided any time upon request.